CHAPTER V—USE OF FUNDING IN SUBSTITUTE CARE

5.01 Determining How to Exclude Room and Board Costs when Participants Reside in Substitute Care

County agencies must be able to document that costs incurred for all Waiver participants including those participants residing in substitute care, do not include room or board expenses. This is because Federal law bars using Medicaid Waiver funds for participant room and board. Room and board must be excluded from Waiver claims when these costs are built into the overall rate charged by the provider.

County staff must calculate room and board for each individual participant. County agencies have broad discretion in how to calculate room and board expenses for a particular person at a particular facility. They may use the model form, "Calculating Expenses for a Substitute Care Facility," from the CBRF Model Contract or any other methodology that fairly allocates room and board costs to residents of the particular facility. The methodology and the calculation for any Waiver participant are subject to Department approval.

5.02 Determining a Participant's Ability to Contribute toward Room and Board in Substitute Care

Room and board costs are usually paid by the Waiver participant using his/her own resources. When room and board costs exceed the participant's available resources, sources of funding other than the Medicaid Waivers must be used.

The completed Financial Eligibility and Cost-Sharing Worksheet (DDES Form 919) or CARES contain information to help determine the Waiver participant's ability to pay room and board, however, DDES Form 920 must be used for all Waiver-eligible individuals who reside in a substitute care living arrangement (see **Appendix P)**.

The amount on line 7 of DDES Form 920 is the maximum obligation of the Group A individual for room and board in the living arrangement. The amount on line 15 is the maximum obligation of the Group B or Group C individual for room and board in the living arrangement**.** If the individual's maximum obligation is less than the actual room and board rate, the balance of room and board costs may be paid with COP, community aids or other funds. If the individual's maximum obligation is greater than the actual room and board rate, that is, if there is an excess of participant income (regardless of source) after the room and board charges and the deductions listed above, the excess represents additional discretionary income that is to be retained by the participant. This additional discretionary income is the participant's to use; it may not be used to pay for any service covered by the Waiver including the cost of care and supervision by the substitute care provider.

Participants residing in substitute care who have a cost share obligation continue to pay that cost share amount toward Waiver services.

5.03 Funding Substitute Care Costs During Resident Absence

Federal regulations prohibit the use of Medicaid Waiver dollars for otherwise allowable substitute cares cost while the participant resides in a hospital, a nursing home or an ICF-MR. Counties may, however cover these costs by building them into the daily rate of the substitute care setting in anticipation of such absenses. For example, if a Waiver participant resides in a CBRF and spends 20 days a year in a hospital, the annual cost for covered CBRF expenses could be averaged over the 345 days (units) of actual service instead of 365 days per year. This process of building costs into the rate can be done at any time during the year. Adjustments may be made monthly or annually, at the end of the year. There is no required methodology for utilizing this option so long as final Waiver billing reflects actual units of service provided and actual, allowable costs.

5.04 Use of Waiver Funding in CBRFs and Children's Group Homes

Section 46.275 (5) (b) (5) and S. 46.278 (6) (a) and the provisions of all of the CMS-approved Waivers bar the use of CIP 1A, CIP 1B and BI Waiver funds for services in CBRFs or Children's Group Homes that are larger than 8 beds under all circumstances. The approved Waiver from CMS bars the use of Children's Group Homes for CLTS.

CBRFs that are licensed for five or eight can only be used and funded with Waiver funds if the county receives prior approval from the Department. CBRFs may not be used in the CLTS Waivers. With the exception of Respite Care, Children's Group Homes licensed for 5-8 beds are not a covered service and are not an allowable living arrangement for children served in any Wavier programs covered by this chapter. No variance process for Children's Group Homes is available to make exceptions to this regulation.

5.05 Variance Approval Considerations and Justifications for Use of Waiver Funding in CBRFs

No Waiver participant may reside in a CBRF licensed for five and up to eight beds unless the county applies for and receives approval for a variance. Any variance approval applies to the Waiver participant and not the facility. This means that variances are not transferable to other individuals either currently served by the facility or who might be served in the future. All variances must be time-limited and other conditions of approval may be imposed. A variance to the four-bed CBRF limit may be granted for any one of the following reasons:

1. Needs of the Individual:

A variance may be granted if the individual has needs which can be most effectively addressed by the particular provider because the provider has specialized expertise or offers other unique services, staff or facilities in the geographic area where the person wants to live. For example, a variance request may be appropriate if there is a CBRF that specializes in the care of individuals with Prader-Willi Syndrome and this is the only specialized provider in that county. However, if a larger living arrangement is not essential for the individual or if the individual's needs cannot be adequately met in the larger setting requested, the variance request may be denied or approved with conditions and limitations imposed.

2. Relocation Deadline:
   A variance may be granted if the county must relocate an individual from an institution in a short period of time due to the impending closure of the institution and an appropriate smaller and/or less restrictive facility or natural home is not immediately available and cannot be developed in a timely way. For these variances, time limitations on the duration of the variance will be imposed.

3. High Cost of Care:
   A variance may be granted if at any time after the approval of the person's initial service plan, the cost of serving the individual in a smaller residence rises because of changed service needs, is substantially greater than the cost of a the larger CBRF and the county lacks resources to finance the person at the higher cost. A high cost of care variance may also be granted if at any time after the approval of the initial service plan, the cost of serving the person in a smaller residence rises to the threshold for termination of Waiver services described in Chapter 2, Section 2.09 A. 1. The variance will be granted if the use of the larger facility would avoid termination or institutionalization.

4. Waiver Participant Choice:
   A variance may be granted if the person or the guardian requests a CBRF provider so long as the cost of this provider is not more than the cost the county would incur if other providers not requiring a variance were used. In this circumstance, the county must provide evidence that the participant or the guardian was given information needed to make an informed choice.

5.06 Variance Approval Process and Submittal Requirements for Use of Funding in CBRFs

To make a request for a variance for CIP IA, CIP IB or BI Waiver participants to enable them to use and live in CBRFs, the county agency must submit the following information to the assigned CIS in writing:

1. The reason(s) for the requested variance using one of the listed reasons contained in Section 5.05.

2. A narrative description of the situation of the Waiver participant who is the subject of this variance request.

3. If the request involves the needs of the individual, describe these and the reasons why this provider and setting is the best option and the efforts made to secure alternatives.

4. If the county faces a relocation deadline, describe the time frames involved in the closure or downsizing of the subject facility, the number of other prospective Waiver participants from that county and the efforts made to secure alternatives.

5. If the request involves high cost issues, please explain and document these in sufficient detail to justify the variance.

6. If the request involves participant choice, include locally developed materials that indicate that the participant and the guardian were informed of alternatives and made this choice with the full knowledge of these. This document must be signed by the participant and guardian (as appropriate), contain a description of the specific alternatives mentioned and describe the process used to inform the participant and guardian of the alternatives.

7. A description of smaller residential settings used in the county's provider network, the county staff who are typically available to recruit and or solicit other kinds of providers who might be considered (such as the adult family home coordinator) and specific fiscal or other barriers to the use of a smaller setting.

8. A description of the proposed CBRF including size, location, staffing numbers and pattern, other people living in the facility, the typical weekly schedule of activities and any special skills or abilities found in the staff of the facility.

9. A description of specific strategies the facility uses to enhance individualization and social integration and how it addresses the limitations associated with larger settings and a plan to mitigate the limitations.

5.07 Criteria for Approval of Variance Requests for CBRFs

Variances will be granted if the request meets all of the submission requirements in this section and presents adequate justification for the request in light of the reason offered.

5.08 Exception to Approval

Even when a request meets all other criteria previously listed, no request may be granted in situations where the proposed residence is structurally connected to another facility and the total licensed beds in the combined facilities is greater than eight.